



**BEFORE THE APPEAL COMMITTEE OF THE COUNCIL FOR MEDICAL
SCHEMES (SECTION 48 APPEAL)**

**HELD VIA MICROSOFT TEAMS VIDEO AND AUDIO-CONFERENCING
TECHNOLOGY.**

(Instituted in terms of the Medical Schemes Act No 131 of 1998)

In the matter between

Ref number: CMS 86522

Ms. O

Appellant

And

Discovery Health Medical Scheme

Respondent

Panel: Dr K. Chetty; Dr X. Ngobese; Ms P. Beck.

Date of hearing: 8 October 2025.

Date of ruling: 26 October 2025.

RULING AND REASONS

THE PARTIES

1. The Appellant is Ms O (The “Appellant” or “Member”), a Member of Discovery Health Medical Scheme.
2. The Respondent is Discovery Health Medical Scheme (The “Respondent or the “Scheme”), registered and regulated under the Medical Schemes Act, Act 131 of 1998 (the “MSA” or “Act”).
3. Ms T, Legal Advisor for Discovery Health appeared for the Respondent.
4. Ms S, Legal Advisor for Discovery Health was also present.
5. Dr Z, Medical Advisor for Discovery Health Medical Scheme was also present.

BACKGROUND

6. The Appellant, Ms. O is a Member of the Discovery Health Medical Scheme.
7. Ms. O was diagnosed with breast cancer in March 2022. She underwent a bilateral mastectomy in December 2022.
8. Ms. O elected to undergo Deep Inferior Epigastric Perforator (DIEP) flap reconstructive surgery in April 2024, preferring its natural results and the reduced number of surgical interventions required.
9. Discovery partially settled the claim, paying R43,542 out of a total of R129,494.31, and cited the use of a non-Designated Service Provider ("non-DSP") as grounds for the shortfall.
10. Discovery Health Medical Scheme’s KeyCare Core Plan covers the costs of non-DSP specialists up to 100% of the Discovery Health Rate. Any shortfall above this rate is for the member’s account.
11. Discovery identified a DSP surgeon located within a radius of 20 kilometres from Ms. O’s residence, who, according to the scheme, was capable of performing the required reconstructive procedure.

12. The selection of Dr. F, a non-DSP, was considered voluntary by Discovery. Accordingly, the Scheme states that the resultant shortfall in payment was justified under the scheme's rules.
13. The Registrar dismissed the complaint, finding that the reconstructive procedure was elective and pre-scheduled, and not an emergency.
14. Ms. O has appealed the Registrar's decision. She asserts that Dr. F is the only surgeon capable of performing the DIEP flap procedure.

THE REGISTRAR'S RULING

15. The Registrar's Ruling was issued on 7th January 2025.
16. The Registrar ruled that the Respondents decision to fund Dr F's account up to the scheme rate was justified as the health care provider is a non-DSP of the Respondent and services were obtained voluntarily. The complaint against the Respondent is accordingly dismissed.
17. The Member is now appealing this decision in terms of Section 48 Appeal.

APPLICATION TYPE AND RELIEF SOUGHT

18. This is an appeal under section 48(1) of the Medical Schemes Act (the "MSA or the Act").¹ This section provides that:
 - a. *"(1) Any person who is aggrieved by any decision relating to the settlement of a complaint or dispute may appeal against such decision to the Council".*
19. The Appeals Committee heard the appeal on 8 October, 2025 via an audio and video conferencing link.

RELEVANT STATUTORY AND REGULATORY PROVISIONS

20. The relationship between the Scheme and the Member is governed by the terms of the contract ("the Schemes rules") the Scheme concluded with

¹ Medical Schemes Act 131 of 1998 as amended by Act 55 of 2001; Section 48(1); Proc 13/GG 19725/19990129

Member. The contract in turn is governed by the “MSA” and the regulations (as amended) made in terms of the Act.

21. This is a wide appeal. The Appeals Committee may consider the matter afresh and is not restricted to the record of proceedings that were before the Registrar.
22. The burden of proof rests on the Appellant who must prove on a balance of probabilities that the appeal should succeed.

THE ISSUE IN DISPUTE

23. The issue in dispute is whether the Scheme was correct to not fund the account for services rendered in full on the basis that it constitutes voluntary use of a non-DSP.

APPELLANTS SUBMISSION

24. The Appellant Ms.O joined Discovery Health on 1st February 2015 and is currently registered on the KeyCare Core benefit plan.
25. Ms. O was diagnosed with breast cancer in March 2022 and subsequently had a bilateral mastectomy in December 2022.
26. The Appellant subsequently consulted with Dr D with regard to reconstruction surgery. She was informed by Dr D that she would need to have three small surgeries and insert silicone implants. She indicated that this would mean taking down time from work and she did not want silicone implants.
27. The doctor advised that a DIEP FLAP (Deep Inferior Epigastric Perforator flap) reconstructive surgery could be done, which was performed on April 11th 2024 by Dr F. This procedure uses the patient's own fat and tissue (autologous reconstruction) and is a once-off surgery.
28. The treating specialist, Dr F, noted that this complex procedure was necessary as her local breast tissue was severely damaged by scarring, thin soft-tissue cover, and radiotherapy⁵.
29. Ms. O states that Dr F is the only doctor in South Africa who can perform this specific type of surgery and she was not advised of any other surgeon who could perform the procedure.

30. The Appellant submitted motivations from the doctor explaining why the DIEP FLAP was the best option, including:
- The alternative option would require about three smaller surgeries and the use of silicone implants, which she did not want.
 - The alternative would lead to longer recovery times and more time off work.
 - The DIEP flap was necessary for a natural-feeling result after her double mastectomy.
 - The procedure is very complex because of the scarring.
31. The Appellant hereby appeals the decision of the Discovery Health Medical Scheme to only partially fund the costs of the reconstructive surgery performed by Dr F, contending that the procedure should have been covered in full under the Scheme's obligations.

RESPONDENTS SUBMISSION

32. The Appellant O has been a member of Discovery Health since 1 February 2015 on the KeyCare Core Plan.
33. The Respondent agrees that the treatment provided to the Appellant, encompassing both mastectomy and reconstructive surgery following a diagnosis of breast cancer, qualifies as a Prescribed Minimum Benefit (PMB).
34. The Scheme asserts that it has discharged its statutory obligation by covering the hospital expenses and the professional services of the treating practitioner at the Discovery Rate, as required for PMB conditions.
35. The Respondent states that the KeyCare Plus Option, a network-based plan governed by the Scheme Rules, which contractually obliges members to utilise Designated Service Providers (DSPs) for treatment of PMB conditions except in cases of emergency.
36. The Respondent argues that the Scheme's position is anchored in Regulation 8(1) of the Medical Schemes Act, which permits the designation of service providers for the management of PMB conditions.
37. The Respondent states that the Member consulted with F, who is a non-DSP, regarding her breast reconstructive treatment options on 17th October 2023. Dr

- F submitted a claim of R1200 for this consultation, which the scheme funded up to 100% of the Discovery rate (R505,50).
38. On 7th December 2023, the member consulted with Dr X regarding her breast reconstructive treatment options. The practice submitted a claim of R556,10 for this consultation which was fully funded by the scheme as Dr X is a DSP plastic and reconstructive surgeon.
 39. On 12th March 2024, Dr F practice contacted the scheme to request authorisation for the member's planned admission scheduled for 11th April 2024 under the care of Dr F. The Scheme confirmed that authorisation was approved, an informed Dr F's practice that is not a DSP and as such the cost will be funded up to 100% of scheme rates
 40. The Respondent submits that the DIEP FLAP procedure was a scheduled, non-emergency admission, and that the Appellant had sufficient opportunity to comply with the network requirements, as authorisation was requested well in advance.
 41. The Scheme avers that while Dr. F may possess particular expertise, reconstructive surgery of the kind required by the Appellant is, in fact, available within the KeyCare network and that the Scheme had identified a DSP within reasonable proximity to the Member.
 42. It is therefore contended that the Appellant voluntarily elected to be treated by Dr. F, a practitioner who is not a DSP and whose fees exceed the Discovery Rate. This voluntary choice, triggers the limitation of funding to the amount that would have been paid to a DSP.
 43. The Scheme submits that its funding decision was justified and correct, in accordance within the Scheme's Rules.
 44. The Scheme accordingly requests that the appeal be dismissed and that the Registrar's decision be confirmed.

DISCUSSION AND ANALYSIS

The Appeals Committee considered papers filed in this appeal; the further submissions the party's made; the relevant provisions of the Medical Schemes Act; and the Rules of the Scheme.

45. It is common cause that

- a. The Appellant has been a member of the Discovery Health Medical Scheme since February 2015 and covered on the KeyCare Core benefit option.
 - b. The Member was diagnosed with breast cancer in March 2022 and subsequently had a bilateral mastectomy in December 2022, reconstructive surgery in April 2024, which are Prescribed Minimum Benefit (PMB) condition.
46. The key issues to be determined is whether the use of the non-DSP provider, Dr. F was voluntary or involuntary, or whether the treatment received was under circumstances or locations which reasonably precluded the use of Scheme's DSP.
47. In terms of Regulation 8 of the Regulations under the Act, medical schemes are entitled to stipulate in their rules that members must utilise DSP's for PMB conditions. In terms of Regulation 8(1) schemes must fund PMB conditions in full but, Regulation 8(1) must be read with Regulations 8(2) and 8(3) and cannot be read in isolation. In terms of Regulation 8(2) a Scheme may apply a co-payment or deductible if a member made use of a non-DSP, unless it can be considered as "involuntary" use of a non-DSP as stipulated in Regulation 8(3)(a)(c).
- (1) *A beneficiary will be deemed to have involuntarily obtained a service from a provider other than a designated service provider, if -*
 - a) *The service is not available from the designated service provider or would not be provided without unreasonable delay*
 - b) *Immediate medical or surgical treatment for a prescribed minimum benefit condition was required under circumstances or at locations which reasonably precluded the beneficiary from obtaining such treatment from a designated service provider; or*
 - a. *There was no designated service provider within reasonable proximity of the beneficiary's ordinary place of business or personal residence*
48. The Scheme stated that the Appellant and the doctors practice was informed that Dr. F was a non-DSP and the scheme tariffs will apply.
49. The Appellant stated quite clearly in her affidavit: "*After my consultation with Dr X I learned that the procedure that she can do would mean I had to have about 3 small surgeries, meaning I would have to take downtime from work every time*

I have this small surgery. Secondly it will mean I must put in silicon breast which is not what I wanted”.

50. Accordingly, the Appellant made a voluntary decision to seek services from the non-DSP provider, Dr. F, as she reasonably wished to avoid the three surgeries and implants. However, the primary issue remains that the choice of doctor was made voluntarily.
51. The Appellant further argued that “*Dr. F is the only doctor in South Africa that can perform this type of surgery*”. The Scheme has indicated that there is an alternative doctor available—a DSP plastic and reconstructive surgeon—located within reasonable proximity to the member's residence. Consequently, the Appellant's argument is no longer applicable.
52. Authorisation for the procedure was requested on 12th March 2024 for the members planned admission scheduled for 11th April 2024. Accordingly, the criteria for immediate medical or surgical intervention under prescribed minimum benefit conditions were not satisfied; therefore, this procedure cannot be classified as an emergency.

FINDINGS

53. The Appeals Committee determines that the Member's circumstances do not meet any of the criteria specified in Regulation 8(3), and her utilisation of a non-DSP cannot be considered as involuntary.
54. The Member is deemed to have made voluntary use of a non-DSP.
55. The Scheme has correctly applied Regulation 8(2) in this case and funded the claims at schemes rates due to voluntary use of a non-DSP.

ORDER

Having considered the matter the Appeals Committee orders that:

- b. The appeal is dismissed.
- c. The decision of the Registrar is upheld.

d. There is no order to costs.

Dated at Johannesburg on 26 October 2025

Dr KS Chetty (For and on behalf of the Appeals Committee)

Concurring:

Dr X. Ngobese

Ms P. Beck.